**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

J T DILGER JR MD
6718 MONTAY BAY DRIVE
SPRING TX 77389

**Respondent Name**

TRUCK INSURANCE EXCHANGE

**Carrier's Austin Representative Box**

Box Number 14

**MFDR Tracking Number**

M4-11-1661-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Designated Doctor Exam for MMI filed 7/19/10...DDE filed 7/19/10"

**Amount in Dispute:** $650.00 + interest for 200 days

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor sought reimbursement of $650 for date of service 07/15/2010. A check for that amount was issued on 08/05/2010. However, the requestor did not receive the check and therefore, it was not cashed. The Requestor asked Carrier to cancel the original check and issue a new check. The check was re-issued on 02/09/11 and it was cashed on 03/02/11. Therefore, this matter has been resolved…"

**Response Submitted by:** Stone Loughlin & Swanson, LLP, 3508 Far West Blvd., Suite 200, Austin, TX 78731

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 15, 2010 | 99456-WP-W5 | $650.00 + interest for 200 days | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §134.130 sets out the procedures for Interest for Late Payment on Medical Bills and Refunds.
2. 28 Texas Administrative Code §133.240 sets out procedures for medical payment and denials
3. Texas Labor Code §413.019 sets out procedures for Interest Earned for Delayed Payment, Refund, or Overpayment regarding medical services and fees.
4. Texas Labor Code §401.023 sets out procedures for computation of Interest or Discount Rate.
5. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
6. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 24, 2010
   - B13 – Payment for service may have been previously paid
   - R01 – Duplicate Billing

   Explanation of benefits dated December 17, 2010
   - 168 – No additional allowance recommended
   - 193 – Original payment decision maintained

**Issues**

1. What is the Maximum Allowable Reimbursement (MAR) for CPT Code 99456-WP-W5?
2. What is the interest due per 28 Texas Administrative Code §134.130?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor billed the amount of $650.00 for CPT code 99456-WP-W5 with 1 (one) unit in Box 24G of the CMS-1500 for a Designated Doctor Examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that the doctor assigned MMI. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The requestor submitted documentation to support the Impairment Rating was performed per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the right shoulder (upper extremity) is per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) with the Range of Motion (ROM) IR method and the Maximum Allowable Reimbursement (MAR) for the Impairment Rating is $300.00. The combined MMI/IR MAR is $650.00. Documentation and payment history screen received from the respondent on March 3, 2011 indicates that the insurance carrier paid $650.00 plus $18.26 interest under check number 8812852032; therefore, no additional amount is due for 99456-WP-W5.
2. The requestor alleges that interest is due for the service in dispute. Pursuant to 28 Texas Administrative Code §134.130(a) "Insurance carriers shall pay interest on medical bills paid on or after the 60th day after the insurance carrier originally received the complete medical bill, in accordance with §133.240 of this title (relating to Medical Payment and Denials). Additionally, 28 Texas Administrative Code §134.130(c) states, "The rate of interest to be paid shall be the rate calculated in accordance with Labor code §401.023 and in effect on the date the payment was made." On April 20, 2012, the division contacted the carrier via memorandum to request information/documentation to establish the date that the carrier received a complete medical bill for the service in dispute. The carrier's responsive documents were compared to the documentation submitted by the requestor in this case. The provider's documentation supports that the requestor in this fee dispute first submitted the medical bill on July 19, 2010 to fax number 18668463114. Documentation from the carrier supports that the date that the carrier received the medical bill was July 20, 2010, at fax number 18668463114. The documentation supports that July 20, 2010 is the common date and common fax number among the parties for which receipt of the bill can be established. Therefore, the division concludes that the date the carrier originally received the complete medical bill is July 20, 2010.
3. The respondent reimbursed the requestor the amount of $18.26 for interest due. In accordance with 28 Texas Administrative Code §134.130, the appropriate amount due for interest is $9.81. Therefore, no additional reimbursement is due.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | May 18, 2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.